Medicare The Official U.S. Government Site for People with Medicare

Important Information About Your Online Enrollment

If you currently have health coverage from an employer or union, joining this plan could affect your employer or union health benefits. You could lose your employer or union health coverage if you join this plan. Read the communications your employer or union sends you. If you have questions, visit their website, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

By completing this enrollment application, I agree to the following:

I understand that this plan is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Parts A and B. I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave or make changes only at certain times of the year when an enrollment period is available (Example: October 15 – December 7 of every year), or under certain special circumstances.

This plan serves a specific service area. If I move out of the area that this plan serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of this plan, I have the right to appeal plan decisions about payment or services if I disagree. I will read the documents that this plan sends to me when I get them to know which rules I must follow in order to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date my coverage with this plan begins, I must get all of my health care from this plan, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by the plan and other services contained in my plan's Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR THE PLAN I HAVE SELECTED WILL PAY FOR THE SERVICES.**

Release of Information:

By joining this Medicare health plan, I acknowledge that this plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that this plan will release my information, including my prescription drug event data if I am enrolling in a plan with prescription drug coverage, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my submission (or the submission of the person authorized to act on my behalf under the laws of the State where I live) of this application means that I have read and understand the contents of this application. If submitted by an authorized individual (as described above), this

submission certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by Medicare.

To Any Legal Authorized Representatives:

I understand that I am the person authorized to act on behalf of the individual listed on this enrollment form under the laws of the State where the individual resides. My agreement on this application means that I have read and understand the contents of this application and certifies that: 1) I am authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by the plan or by Medicare. Please click the "Agree/Submit Enrollment " button below to continue.